STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS RHODE ISLAND DEPARTMENT OF LABOR AND TRAINING DIVISION OF LABOR STANDARDS 1511 PONTIAC AVE. P.O. BOX 20390, CRANSTON, RI 02920 FAX NUMBER (401) 462-8530

NON—PAYMENT OF WAGES COMPLAINT FORM

Employee information:			
Name :	Soc. Sec.#		
Address:			
			Zip
Date of birth:	_ Work phone:	-	Home:
What type of work did yo	u perform?		
EMPLOYER INFORMA	ΓΙΟΝ: (complaint v	vill not be accepto	ed unless this section is completed)
Company name:			Phone:
Address			
			Zip:
President/Owner Name			Title;
Local Manager Name:			
Place work was performed	d if different from a	bove:	
Date of hire	Last	day worked	
Were you discharged	or d	id you leave	
BEFORE THIS OFFICE TO DEMAND YOUR WAGES?	S. HAVE YOU BE	EN IN PERSON	M, YOU MUST GO IN PERSON AND TO DEMAND YOUR
When?			
With whom did you speak	:?		Title:
Reason for non-payment_			
Rate of Pay:\$	_ per hour/week		_Unpaid wages:
What dates did you work	for the money which	you claim you a	are owed:
From//_	to		Total amount owed:\$

Have you signed a contract as a consultant or independent cont	eractor?
Do you have an attorney representing you in this matter?	
Have you taken any other action against your employer in this	matter?
If yes, please explain:	
Are you willing to fully cooperate with the Attorney General's	Office, including appearing in court
EXPLAIN IN DETAIL the facts relating to why you were not p If your complaint involves vacation pay, briefly explain how yo year, one week after one year, monthly accrual, etc.) Please atta stubs that will support your claim.	u earned vacation time (e.g. one week per
I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWI STATEMENT OF THE FACTS RELATING TO MY COMPL	
Signature:	Date:
Print Name:	

ONCE YOUR COMPLAINT IS RECEIVED, A COPY MAY BE FORWARDED TO YOUR EMPLOYER

PLEASE PRINT CLAIM FORM, SIGN AND FORWARD TO THE ADDRESS(AT)TOP OF FORM